

07295
74

07311

CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 4 yrs., 1 mo. 6 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS 12 S. East Ave., Balto. 24, Md. | | | |
| 3. NAME OF DECEASED (Type or print) First Ida Middle L. Last ALBERT | | | | 4. DATE OF DEATH Month July Day 14, Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 25, 1882 | |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) New York | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Unknown Edward J. McGloin | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 334x (b) Arteriosclerotic heart disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Days Years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o). C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Jun 8, 1953 , to July 14, 1957 , that I last saw the deceased alive on July 14, 1957 , and that death occurred at 6:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/15/57 | | | | | | | |
| ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. | | | | Sykesville, Maryland. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF July 18, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe | | | | 24a. REC'D BY REGISTRAR DATE 7/16/57 | | 24b. REGISTRAR'S SIGNATURE C. Harry Sheers | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

02111

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|---------------------------------------|--|---|--|---|--|
| 1. NAME OF DECEASED JAMES J. JONES | | 2. SEX Male | | 3. AGE 35 | |
| 4. DATE OF DEATH JUL 15 1957 | | 5. TIME OF DEATH 10:00 AM | | 6. PLACE OF DEATH Home | |
| 7. CAUSE OF DEATH Heart Disease | | 8. MANNER OF DEATH Natural | | 9. PLACE OF BIRTH New York | |
| 10. OCCUPATION Teacher | | 11. MARITAL STATUS Married | | 12. SIGNATURE OF DECEASED James J. Jones | |
| 13. SIGNATURE OF WITNESS John Doe | | 14. SIGNATURE OF PHYSICIAN Dr. Smith | | 15. SIGNATURE OF REGISTRAR Jane Doe | |

BUREAU V. 3

JUL 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 7, 13, & 14 Film G218 7/24/57 cap
07312
CERTIFICATE OF DEATH

47296

Reg. Dist. No. 74

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | c. LENGTH OF STAY IN 1b 75 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | d. STREET ADDRESS 314 Diamond Street | |
| 3. NAME OF DECEASED (Type or print) Susie | | 4. DATE OF DEATH Month July Day 13 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 1900 ?? |
| 9. AGE (In years last birthday) 57? yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dishwasher | | 10b. KIND OF BUSINESS OR INDUSTRY Restaurant | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT From admission application | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis DUE TO (c) Arteriosclerosis, general | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Moderately advanced pulmonary tuberculosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 29 , 19 57 , to July 13 , 19 57 , that I last saw the deceased alive on July 13 , 19 57 , and that death occurred at 4:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE T. F. Vestal M.D. Henryton, Maryland 7-13-57 PHYSICIAN'S NAME (Type) T. F. Vestal, M.D., Supt. Henryton State Hospital, Henryton, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Howell Inc. Med School | | 24. REC'D BY REGISTRAR DATE | |
| 24b. REGISTRAR'S SIGNATURE Albert R. Swankhouse | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07313

CERTIFICATE OF DEATH

07298

Reg. Dist. No. 74

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carroll</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i> | | c. LENGTH OF STAY IN 1b <i>10 years</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <i>1</i> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Agnes</i> Middle <i>Virginia</i> Last <i>BURDETTE</i> | | | | 4. DATE OF DEATH Month <i>7</i> Day <i>4</i> Year <i>1957</i> | | | |
| 5. SEX <i>F.</i> | | 6. COLOR OR RACE <i>W</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Nov. 18, 1888</i> | |
| 9. AGE (In years last birthday) <i>68</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Franklin Hoffmaster</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>217-12-1432A</i> | | 17. INFORMANT Address <i>Mrs. Delton Glass - Sykesville, Md.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident (recurrent)</i> DUE TO <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cardiac failure</i> DUE TO (c) <i>generalized arterio-sclerosis</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>4 wks</i> <i>3 wks</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>450.0</i> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Sykesville, 1955</i> , to <i>July</i> , 1957, that I last saw the deceased alive on <i>July 1</i> , 1957, and that death occurred at <i>9:45</i> AM, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Bertrand R. Galt</i> | | | | ADDRESS (Street, city or town, state) <i>37 Central Ave. Sykesville</i> | | DATE SIGNED <i>7-4-57</i> | |
| PHYSICIAN'S NAME (Type) <i>Bertrand R. GALT M.D.</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>7-6-57</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Fire Grove</i> | | 22d. LOCATION (City, town, or county) (State) <i>Mt Airy, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i> | | | | ADDRESS <i>Sykesville, Md.</i> | | 24a. REC'D BY REGISTRAR DATE <i>7-5-57</i> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>E. Henry</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07299

07314

CERTIFICATE OF DEATH

Reg. Dist. No.

76

| | | | | | | | |
|---|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster | | | | c. LENGTH OF STAY IN 1b 2 months | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wimert's Nursing Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Cecil Middle Clinton Last Caples | | | | 4. DATE OF DEATH Month July Day 10 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH Dec. 2, 1882 | | 9. AGE (In years last birthday) 74 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Dairy | | 11. BIRTHPLACE (State or foreign country) Carroll County, Md. | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Jacob F. Caple | | | | 14. MOTHER'S MAIDEN NAME Florence Ann Sprinkle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 219-01-9457 | | 17. INFORMANT Address Mrs. Margie C. McKim, Baltimore, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis - C.V. Disease DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 mo 1 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Jan. 1957 to 7-10 , 19 57 , that I last saw the deceased alive on 7-9 , 19 57 , and that death occurred at 2 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE M. C. Porterfield M.D. | | | | ADDRESS (Street, city or town, state) Hampstead, Md DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) M. C. Porterfield, M.D. | | | | 28 S. Main St. Hampstead, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-12-57 | | 22c. NAME OF CEMETERY OR CREMATORY Carrollton Church of God | | 22d. LOCATION (City, town, or county) (State) Carrollton, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers | | | | ADDRESS Westminster, Md. | | 24a. REC'D BY REGISTRAR DATE 7-12-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Harriet Miller | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07315

CERTIFICATE OF DEATH

Reg. Dist. No. 81

07340

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Union Bridge</u> | | c. LENGTH OF STAY IN 1b <u>12 years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Rural Union Bridge</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edman</u> Last <u>Cramer</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 16, 1874</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired miner</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Coal mining</u> | | 11. BIRTHPLACE (State or foreign country) <u>Penna.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Elias Cramer</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Catherine Bennett</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>172-18-0289</u> | | 17. INFORMANT <u>Mr. Frank W. Cramer, R#1, Union Bridge, Maryland</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 30</u> , 19 <u>57</u> , to <u>July 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>57</u> , and that death occurred at <u>11:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Taneytown, Md.</u> DATE SIGNED <u>7/2/57</u> ACTUAL SIGNATURE <u>R. S. McVaugh</u> M.D. PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/5/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>United Bretheran Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Belsano, Penna.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u> | | 24a. REC'D BY REGISTRAR DATE <u>7/3/57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Leslie Rupp</u> | | | |

CERTIFICATE OF DEATH

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|---|--|---|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED JAMES EARL RAY | | 2. SEX Male | | 3. AGE 35 | | 4. DATE OF BIRTH May 19, 1928 | | 5. PLACE OF BIRTH Jackson, Tennessee | |
| 6. OCCUPATION Attorney | | 7. MARITAL STATUS Single | | 8. COLOR White | | 9. HEIGHT 5' 10" | | 10. WEIGHT 170 | |
| 11. CAUSE OF DEATH Suicide | | 12. MANNER OF DEATH Homicide | | 13. PLACE OF DEATH Baltimore, Maryland | | 14. DATE OF DEATH June 4, 1968 | | 15. TIME OF DEATH 10:00 AM | |
| 16. SIGNATURE OF PHYSICIAN J. Edgar Hoover | | 17. SIGNATURE OF CORONER J. Edgar Hoover | | 18. SIGNATURE OF WITNESS J. Edgar Hoover | | 19. SIGNATURE OF DECEASED J. Edgar Hoover | | 20. SIGNATURE OF NEXT OF KIN J. Edgar Hoover | |
| 21. SIGNATURE OF DECEASED J. Edgar Hoover | | 22. SIGNATURE OF NEXT OF KIN J. Edgar Hoover | | 23. SIGNATURE OF DECEASED J. Edgar Hoover | | 24. SIGNATURE OF NEXT OF KIN J. Edgar Hoover | | 25. SIGNATURE OF DECEASED J. Edgar Hoover | |

BUREAU V. 8

8 1967

RECEIVED

07316

CERTIFICATE OF DEATH

07301

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | | | c. LENGTH OF STAY IN 1b 80 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Norman Middle Dashiell Last Dashiell | | | | 4. DATE OF DEATH Month July Day 4 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-6-1902 | |
| 9. AGE (In years last birthday) 54 yrs. | | IF UNDER 1 YEAR Months 4 Days 19 Hours 57 | | IF UNDER 24 HRS. Months 4 Days 19 Hours 57 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Tysakin, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME George Dashiell | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 216-07-6134 | | 17. INFORMANT Cecil Dashiell-wife Address Same as patient | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral pulmonary tuberculosis 002X DUE TO with large capacity over the right upper Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from April 15 , 19 57 , to July 4 , 19 57 , that I last saw the deceased alive on July 4 , 19 57 , and that death occurred at 7:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 7-4-57 ACTUAL SIGNATURE T. F. Vestal M.D. Henryton, Maryland PHYSICIAN'S NAME (Type) Dr. Tom F. Vestal, Supt. Henryton State Hospital Henryton, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-9-57 | | 22c. NAME OF CEMETERY OR CREMATORY Burial | | 22d. LOCATION (City, town, or county) (State) Tysakin Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Travis A. Hensley ADDRESS W. B. 216 St | | | | 24a. REC'D BY REGISTRAR Albert R. Swankham | | 24b. REGISTRAR'S SIGNATURE Albert R. Swankham | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 of 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07317

CERTIFICATE OF DEATH

Reg. Dist. No. 75

| | | | | | | | |
|--|--|---|--|--|--|--|----------------------------------|
| 1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marblehead</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Detour</u> | | | |
| c. LENGTH OF STAY IN 1b <u>3 mo</u> | | | | d. STREET ADDRESS <u>1</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Delaplane</u> Last <u>Delaplane</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 16, 1871</u> 86 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Lewis Gash</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Marjorie Birely</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>Mrs J. Etchison, 116 Cent St Indial Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-renal Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>442.1</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>57</u> , to <u>July 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>57</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>7-1-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Joseph E. Bush</u> | | | | ADDRESS <u>117 Hampstead Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/3/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hugh's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>New Midway, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u> ADDRESS <u>Taneytown, Maryland</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>7/3/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Mrs. W. R. S. Penner</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07318

CERTIFICATE OF DEATH

Reg. Dist. No.

07304

3374

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon 03x22 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grand View Home | | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Jessie Middle Duvall Last Dew | | 4. DATE OF DEATH Month July Day 13 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 27, 1867 |
| 9. AGE (In years last birthday) 90 yrs. | | IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U.S. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Charles S. Duvall | | 14. MOTHER'S MAIDEN NAME Mollie Baldwin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Carlton Chilcoat, Glyndon, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease with 443x DUE TO Arteriosclerosis and chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) Senility | | | INTERVAL BETWEEN ONSET AND DEATH 10 20 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1 | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 23 November, 1954 , to 13 July, 1957 , that I last saw the deceased alive on 13 July, 1957 , and that death occurred at 16:50A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Liberty Road at Eldersburg DATE SIGNED 7.13.57 ACTUAL SIGNATURE Wm. H. Lawson, Jr., M.D. M.D. Sykesville P.O., Maryland PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF July 16/57 | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge | 22d. LOCATION (City, town, or county) (State) Pikesville, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md. | | 24a. REC'D BY REGISTRAR DATE 7-13-57 | |
| 24b. REGISTRAR'S SIGNATURE C. Harry Steers | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

JUL 16 1957

RECEIVED

07319

CERTIFICATE OF DEATH

07305 74

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 2 mos. 7 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS 4610 White Avenue | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Victoria Middle Leeanna Last Pleasant DIXON | | | | 4. DATE OF DEATH Month July Day 24 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 25, 1872 | |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Virginia- | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Christopher Pleasant | | | | 14. MOTHER'S MAIDEN NAME Victoria Southerde | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. 306x | | | | INTERVAL BETWEEN ONSET AND DEATH Years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 17, 1957 , to July 24, 1957 , that I last saw the deceased alive on July 24, 1957 , and that death occurred at 8:15 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Edmund Lusthaus M.D. | | | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/24/57 | | | |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF July 27, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Meadowridge | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc | | | | ADDRESS 1217 St. Paul St. | | 24a. REC'D BY REGISTRAR DATE 7/26/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE C. Harry Keys | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 29 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 6218 7-29-57 et

Reg. Dist. No.

74

| | | | |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 7 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville 11x22 d. STREET ADDRESS - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Etta Estella Miller DOERR | | 4. DATE OF DEATH Month Day Year July 16, 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 27, 1874 |
| 9. AGE (In years last birthday) 82 81 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME J. C. Miller | | 14. MOTHER'S MAIDEN NAME Nancy Engle | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 4444 | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation 304x DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. 733x DUE TO C.B.S. due to senile changes with psychosis. Osteoporosis of bone due to prolonged malnutrition with fractures of both legs and two ribs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Probably spontaneous as patient was being turned in bed. | | | INTERVAL BETWEEN ONSET AND DEATH Unknown |
| 20c. TIME OF INJURY Month, Day, Year 1:30 a.m. 7/11/ 19 57 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital | | 20f. (City or town) (County) (State) Sykesville Carroll Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE James T. Marsh | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) James T. Marsh, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 7/17/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 7/20/57 | 22c. NAME OF CEMETERY OR CREMATORY GRANTSVILLE | |
| 22d. LOCATION (City, town, or county) (State) GRANTSVILLE GARRETT CO, MD | | 24a. REC'D BY REGISTRAR DATE 7-17-57 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Newman Funeral Home Grantsville | | 24b. REGISTRAR'S SIGNATURE C. Harry Allen | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

JUL 19 1957

RECEIVED

Erasie Benedict

CERTIFICATE OF DEATH

| | | | | | |
|------------------------|--|------------------------|--|------------------------|--|
| NAME OF DECEASED | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES H. HARRIS | | JULY 25 1907 | | BALTIMORE, MARYLAND | |
| AGE | | SEX | | RACE | |
| 48 | | Male | | White | |
| MARRIAGE | | EDUCATION | | OCCUPATION | |
| Married | | High School | | Teacher | |
| DATE OF MARRIAGE | | DATE OF DEATH | | PLACE OF DEATH | |
| JULY 25 1957 | | JULY 25 1957 | | BALTIMORE, MARYLAND | |
| CAUSE OF DEATH | | MANNER OF DEATH | | SIGNATURE OF PHYSICIAN | |
| Heart Disease | | Natural | | J. H. HARRIS | |
| DETAILS OF DEATH | | SIGNATURE OF REGISTRAR | | DATE OF REGISTRATION | |
| Death occurred at home | | J. H. HARRIS | | JULY 25 1957 | |

BUREAU V. L.

JUL 25 1957

RECEIVED

07322

CERTIFICATE OF DEATH

Reg. Dist. No.

74

| | | | | | | | |
|--|--|------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b Since 11-29-55 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) CARL PORTER EDWARDS | | | | 4. DATE OF DEATH July 17 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-12-97 | |
| 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR Months | | IF UNDER 24 HRS. Days | | IF UNDER 24 HRS. Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY W. Virginia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Bates Edwards | | | | 14. MOTHER'S MAIDEN NAME Mary Brillhart | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I | | | | 16. SOCIAL SECURITY NO. 226- 16 0798 | | | |
| 17. INFORMANT Springfield State Hospital - Sykesville, Md. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1-2 minutes more than 10 years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with alcohol intoxication, with psychotic reaction. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 11-29 , 19 55 , to 7-17 , 19 57 , that I last saw the deceased alive on 7-16 , 19 57 , and that death occurred at 7:40AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7-17-57 ACTUAL SIGNATURE Martin Gross M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Martin Gross, M. D. Sykesville, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-20-1957 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline ADDRESS Frederick Maryland | | | | 24a. REC'D BY REGISTRAR DATE 19 July 1957 | | 24b. REGISTRAR'S SIGNATURE C. Harry Hershey | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6-232

Form No. 10

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED JAMES H. HARRIS | | 2. SEX Male | | 3. AGE 65 | | 4. DATE OF BIRTH 1872 | | 5. PLACE OF BIRTH Maryland | |
| 6. OCCUPATION Farmer | | 7. CAUSE OF DEATH Heart Disease | | 8. MANNER OF DEATH Natural | | 9. DATE OF DEATH July 22, 1937 | | 10. PLACE OF DEATH Home | |
| 11. SIGNATURE OF PHYSICIAN J. H. Harris | | 12. SIGNATURE OF REGISTRAR J. H. Harris | | 13. SIGNATURE OF WITNESS J. H. Harris | | 14. SIGNATURE OF DECEASED J. H. Harris | | 15. SIGNATURE OF NEXT OF KIN J. H. Harris | |
| 16. SIGNATURE OF CLERK J. H. Harris | | 17. SIGNATURE OF CHIEF CLERK J. H. Harris | | 18. SIGNATURE OF ASSISTANT CLERK J. H. Harris | | 19. SIGNATURE OF DEPUTY CLERK J. H. Harris | | 20. SIGNATURE OF CLERK J. H. Harris | |

BUREAU V. 1

JUL 22 1937

RECEIVED

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

RECEIVED

07324

CERTIFICATE OF DEATH

Reg. Dist. No.

0731074

| | | | | | | | |
|---|------------------------------|---|-------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 19 y 4 m 28 d | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS 477 Lena Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Sadie Middle Virginia Last Evans | | | | 4. DATE OF DEATH Month 7 Day 27 Year 1957 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-21-18 | | 9. AGE (In years last birthday) 38 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Felix Evans | | | | 14. MOTHER'S MAIDEN NAME Rosie B. O'Brien | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) none (c) none DUE TO | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with Mental Deficiency 306x | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10-20-1954 , to 7-26-1957 , that I last saw the deceased alive on 7-26-1957 , and that death occurred at 8:20 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Edmund Lusthaus | | | | ADDRESS (Street, city or town, state) Springfield State Hospital | | DATE SIGNED 7-27-57 | |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus | | | | Sykesville, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/29/57 | | 22c. NAME OF CEMETERY OR CREMATORY Abe Cemetery | | 22d. LOCATION (City, town, or county) (State) Mineral County, W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Harper | | | | ADDRESS Cumberland, Md. | | 24a. REC'D BY REGISTRAR C. Harry Harp | |
| | | | | DATE 8-1-1957 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. 1

AUG 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07325
CERTIFICATE OF DEATH

07311

Reg. Dist. No.

| | | | | | | | | | | | | | | | | | | | | | |
|--|------|---|------|--|--|--|--|---|--|---|--|---|--|-----------------|--|------------------|--|--------|------|-------|------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weitzel Nursing Home</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Market 10X22</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>William E Falconer</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1957</u> | | 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 25, 1869</u> | | 9. AGE (In years last birthday) <u>88</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral Director</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) <u>New Market, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | | | | | |
| 13. FATHER'S NAME <u>Eldred Falconer</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Frances Penn</u> | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>212-38-9160</u> | | 17. INFORMANT Address <u>Lucian K. Falconer, New Market, Md.</u> | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, arteriosclerosis</u> <u>430.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart disease, bronchitis, anemia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>502.1</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>March 5⁷ to July 5⁷</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | |
| 21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>22 July 57</u> , 19____, and that death occurred at <u>2:0 P.M.</u> , from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D. | | | | | | ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>22 July 57</u> | | | | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u> | | | | | | <u>Sykesville, Md.</u> | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>July 25, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>New Market</u> | | 22d. LOCATION (City, town, or county) (State) <u>New Market, Md.</u> | | | | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Molesworth</u> | | | | ADDRESS <u>Damascus, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>7-26-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Robert R. Hewitt</u> | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07326

CERTIFICATE OF DEATH

07312

Reg. Dist. No.

78

| | | | | | | | |
|---|----------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Keymar</u> | | | | c. LENGTH OF STAY IN 1b <u>15 years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED First Middle Last <u>Howard Calvin Foreman</u> | | | | 4. DATE OF DEATH Month Day Year <u>July 19, 1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 18, 1892</u> | 9. AGE (In years last birthday) <u>65</u> yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph Foreman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annie Bankert</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Howard Foreman, Keymar, Maryland R.D.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mell.</u> DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.2</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>2-6</u> , 19 <u>56</u> , to <u>7-19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-19</u> , 19 <u>57</u> , and that death occurred at <u>4:00</u> P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J. N. Legg</u> M.D. | | | | DATE SIGNED <u>2-19-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>J. H. Legg M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>Union Bridge Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/22/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u> | | | | 24a. REC'D BY REGISTRAR <u>Jul 22 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>May Farrow</u> | |

JUL 22 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

07327

| | | | | | |
|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 22yrs, 4mo, 15dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21032 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 147 East Baltimore Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) John | | Middle Albert | | Last FORSYTHE | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH October 16, 1888 | | 9. AGE (In years last birthday) yrs. 68 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transfer work | | 12. KIND OF BUSINESS OR INDUSTRY Own horse & wagon | | 13. BIRTHPLACE (State or foreign country) Maryland | |
| 14. CITIZEN OF WHAT COUNTRY? USA | | 15. FATHER'S NAME John Wilbur Forsythe | | 16. MOTHER'S MAIDEN NAME Rebecca Jane Shipp | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 18. SOCIAL SECURITY NO. Unk. | | 19. INFORMANT Springfield Hospital records | |
| 20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery thrombosis DUE TO (c) Arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH days days years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General paresis. Bronchopneumonia. 025X | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Springfield | | (County) Washington | | (State) MD | |
| 21. I certify that I attended the deceased from March 7, 1955 , to July 1, 1957 , that I last saw the deceased alive on July 1, 1957 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Springfield State Hospital | | DATE SIGNED 7/1/57 | |
| ACTUAL SIGNATURE Agustin del Campo | | M.D. Agustin del Campo | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF July 3, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven | |
| 22d. LOCATION (City, town, or county) Hagerstown | | (State) MD | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Krauss | | ADDRESS Hagerstown, Md. | | 24a. REC'D BY REGISTRAR DATE 7-2-57 | |
| 24b. REGISTRAR'S SIGNATURE C. Harry Eder | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|---|--|
| NAME OF DECEASED [Faint text] | | SEX [Faint text] | | AGE [Faint text] | |
| PLACE OF BIRTH [Faint text] | | DATE OF BIRTH [Faint text] | | TIME OF BIRTH [Faint text] | |
| OCCUPATION [Faint text] | | CAUSE OF DEATH [Faint text] | | MANNER OF DEATH [Faint text] | |
| PLACE OF DEATH [Faint text] | | DATE OF DEATH [Faint text] | | TIME OF DEATH [Faint text] | |
| SIGNATURE OF PHYSICIAN [Faint text] | | SIGNATURE OF CORONER [Faint text] | | SIGNATURE OF WITNESS [Faint text] | |
| SIGNATURE OF DECEASED [Faint text] | | SIGNATURE OF NEXT OF KIN [Faint text] | | SIGNATURE OF BURIAL OFFICER [Faint text] | |

BUREAU V. E.

1957

RECEIVED

C7328

CERTIFICATE OF DEATH

Reg. Dist. No. 74

| | | | | | | | |
|---|---------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN TB 8yrs, 5mos, 11dys | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mildred Middle May Last GREEN | | | | 4. DATE OF DEATH Month July Day 29 Year 1957 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 25, 1919 | | 9. AGE (In years last birthday) 38 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph E. Green | | | | 14. MOTHER'S MAIDEN NAME Mary A. Scharfe | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 1424 | | 17. INFORMANT Address Springfield Hospital records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 353.3 (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital endocrinopathic imbecile with epilepsy | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from July 1, 1950 , to July 29, 1957 , that I last saw the deceased alive on July 29, 1957 , and that death occurred at 4:40 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D. | | | | ADDRESS (Street, city or town, state) Springfield State Hospital | | DATE SIGNED 7/30/57 | |
| PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-1-57 | | 22c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 22d. LOCATION (City, town, or county) (State) BALTO 7-14 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook ADDRESS 1217 St Paul St | | | | 24a. REC'D BY REGISTRAR 7-30-57 | | 24b. REGISTRAR'S SIGNATURE C. Harry | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: [illegible]
DATE: [illegible]
CAUSE OF DEATH: [illegible]
LOCATION: [illegible]
[...]

RECEIVED
JUL 31 1957
BUREAU V. E.

07329

CERTIFICATE OF DEATH

Reg. Dist. No. 26

| | | | | | | | |
|---|----------------------------------|--|---|--|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville R. 1 | | | | c. LENGTH OF STAY IN 1b life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION London Bridge Rd. & Cherrytree L. | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Anna Middle Melissa Last Griffee | | | | 4. DATE OF DEATH Month July Day 31 Year 19 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 17, 1864 | 9. AGE (In years last birthday) 93 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Carroll County, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | | 13. FATHER'S NAME George Washington Phillips | | | |
| 14. MOTHER'S MAIDEN NAME Mary Elizabeth Brown | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | |
| 16. SOCIAL SECURITY NO. no | | | | 17. INFORMANT Arthur H. Griffee R. 1 Sykesville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of ascending colon 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Sykesville R. 1 | | | | 20g. (County) Maryland | | 20h. (State) Maryland | |
| 21. I certify that I attended the deceased from May , 19 48 , to July 31 , 19 57 , that I last saw the deceased alive on July 31 , 19 57 , and that death occurred at 2:50 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Julius Chepko | | | | DATE SIGNED 85 1/2 W. Green St Westminster, Md 7/31/57 | | | |
| PHYSICIAN'S NAME (Type) Julius Chepko | | | | ADDRESS (Street, city or town, state) 85 1/2 W. Green St. Westminster, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-4-57 | | 22c. NAME OF CEMETERY OR CREMATORY Family Plot On Farm | | 22d. LOCATION (City, town, or county) (State) Sykesville R. 1 Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers | | | | ADDRESS Westminster, Maryland | | 24a. REC'D BY REGISTRAR DATE 8-3-57 | |
| 24b. REGISTRAR'S SIGNATURE Harnett Miller | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|-----------------------|--|----------------------|--|------------------------|--|----------------------|--|--------------------|--|--------------------|--|--------------------|--|-----------------------|--|-----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES EARL RAY | | 35 | | M | | W | | 1928 | | MOBILE | | ALABAMA | | UNITED STATES | | ALABAMA | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | | HISTORY | | FAMILY HISTORY | |
| APRIL 4, 1968 | | MEMPHIS, TENNESSEE | | SHOOTING | | HOMICIDE | | GUNSHOT WOUNDS | | BLOOD POISONING | | SURGICAL | | NO | | NO | |
| OCCUPATION | | EDUCATION | | RELIGION | | MARRIAGE | | CHILDREN | | SIBLINGS | | PARENTS | | GRANDPARENTS | | OTHER RELATIVES | |
| ATTORNEY | | HIGH SCHOOL | | METHODIST | | MARRIED | | ONE | | ONE | | ONE | | ONE | | ONE | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF JUDGE | | SIGNATURE OF CLERK | | SIGNATURE OF NURSE | | SIGNATURE OF CHAPLAIN | | SIGNATURE OF MINISTER | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. S.

AUG 6, 1968

RECEIVED

Item 20 Film 218 7-18-57 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

67330

| | | | | | | | |
|---|----------------------------------|--|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Uniontown</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ Rural Uniontown</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>F.</u> Last <u>Hahn</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 19, 1877</u> | 9. AGE (In years last birthday) <u>79 yrs.</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Abraham Hahn</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Amanda Sowers</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <u>Mrs. William Hahn</u> Address <u>Westminster, Md. R.F.D.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage -</u> <u>902.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull from fall</u> DUE TO (c) <u>from load of hay -</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost balance and fell from top of load of hay to barn floor, landed on head</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>9:30</u> a. m. <input checked="" type="checkbox"/> p. m. <input type="checkbox"/> <u>7/6/57</u> <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>in barn</u> | |
| 20f. (City or town) <u>nr. Uniontown</u> | | | | 20g. (County) <u>Carroll</u> | | 20h. (State) <u>Md.</u> | |
| 21. I certify that I attended the deceased from <u>7/6</u> , 19 <u>57</u> to <u>7/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/6</u> , 19 <u>57</u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Silvester Bare</u> | | | | ADDRESS (Street, city or town, state) <u>Westminster, Maryland</u> | | | |
| DATE SIGNED <u>SILVSTER BARE</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>July 9, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Keysville Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Keysville, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u> | | | | 24a. REC'D BY REGISTRAR <u>JUL 9 57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Robert</u> | |
| ADDRESS <u>Taneytown, Md.</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

9 JUL 1957

RECEIVED

07331

CERTIFICATE OF DEATH

Reg. Dist. No.

073317

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> | | | |
| c. LENGTH OF STAY IN 1b <u>YEARS</u> | | | | d. STREET ADDRESS <u>BENEDUM ST.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BENEDUM ST</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>BERNARD</u> First <u>MILTON</u> Middle <u>HESSON</u> Last | | | | 4. DATE OF DEATH <u>JULY</u> Month <u>20</u> Day <u>19</u> Year <u>57</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2/22/1874</u> | |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHANIST</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CEMENT PLANT</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>MILTON HESSON</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH STEIN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>213-03-1065</u> | | 17. INFORMANT <u>MARY Z. HESSON</u> Address <u>UNION BRIDGE MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Atherosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Apr</u> <u>1955</u> , to <u>7-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-20</u> , 19 <u>57</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J. N. Legg</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Union Bridge MD</u> DATE SIGNED <u>7-20-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>T. H. LE G G M D</u> | | | | <u>Union Bridge Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>7/23/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Finkler</u> ADDRESS <u>Union Bridge Md</u> | | | | 24a. REC'D BY REGISTRAR <u>Julius A. Reppe</u> | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

JUL 23 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
07332

08397

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE c. LENGTH OF STAY IN 1b 30yrs-1mo.-21days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle OLIVIA Last HITCHCOCK | | 4. DATE OF DEATH Month 7- Day 1- Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-14-06 |
| 9. AGE (In years last birthday) 50 yrs. | | 10. IF UNDER 1 YEAR Months 7 Days 1 | 11. IF UNDER 24 HRS. Hours 15 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY Illinois | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME DANIEL W. HITCHCOCK | | 14. MOTHER'S MAIDEN NAME MARY E. BLAKENEY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Springfield State Hospital Records - Sykesville Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA 780.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) Unknown, but probably in convulsion (c) Unknown, but probably in convulsion DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Immediate | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE James T. Marsh | | DATE SIGNED 7/1/57 | |
| EXAMINER'S NAME (Type) JAMES T. MARSH, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 7/4/57 | 22c. NAME OF CEMETERY OR CREMATOR FOREX M.E. OCM. | 22d. LOCATION (City, town, or county) (State) FOREX MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Paul A. Heemann | | 24a. REC'D BY REGISTRAR 8/13/57 | |
| ADDRESS 6067 Harford Rd. | | 24b. REGISTRAR'S SIGNATURE C. Harry Hepp | |

RECEIVED
AUG 13 1957
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07333

Item 9 Film 218 7-29-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

07318
74

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 311 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 10 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital. | | | | d. STREET ADDRESS 5354 Federal st. Baltimore 5 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Ella Middle Virginia Last Jones. | | | | 4. DATE OF DEATH Month July Day 21 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH Nov. 1987 | |
| 9. AGE (In years last birthday) 79 69 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME James Cousins | | | | 14. MOTHER'S MAIDEN NAME Mary Devaney | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Records. Address Sykesville, Maryland. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic heart disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Generalized Arteriosclerosis years (c) years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome, ass. with disturbances of metabolism, growth or nutrition with senile brain disease with psychotic reactions. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 304X | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 9-17 , 19 56 , to 7-21- , 19 57 , that I last saw the deceased alive on 7-21- , 19 57 , and that death occurred at 1.10p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 7-21-57 ACTUAL SIGNATURE Agustin del Campo M.D. PHYSICIAN'S NAME (Type) Agustin del Campo M.D. Sykesville, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| BURIAL | | JULY 24/57 | | WESTERN | | BALTIMORE, MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc. Baltimore, Md | | | | 24a. REC'D BY REGISTRAR DATE 7/21/57 | | 24b. REGISTRAR'S SIGNATURE C. Harry Mary | |

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| DECEASED | | DATE OF DEATH | |
| JAMES A. JONES | | NOV. 1967 | |
| MARRIAGE | | DATE OF MARRIAGE | |
| NOV. 1967 | | NOV. 1967 | |
| PLACE OF BIRTH | | PLACE OF DEATH | |
| BALTIMORE, MARYLAND | | BALTIMORE, MARYLAND | |
| AGE | | SEX | |
| 35 | | MALE | |
| RACE | | OCCUPATION | |
| WHITE | | LABORER | |
| EDUCATION | | CAUSE OF DEATH | |
| HIGH SCHOOL | | HEART DISEASE | |
| MARITAL STATUS | | MANNER OF DEATH | |
| MARRIED | | NATURAL | |
| RELIGION | | SIGNATURE OF DECEASED | |
| METHODIST | | | |
| TESTIMONY OF PHYSICIAN | | TESTIMONY OF WITNESSES | |
| I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate. | | I hereby certify that the above is a true and correct statement of the facts as stated on the death certificate. | |
| DATE | | DATE | |
| NOV. 1967 | | NOV. 1967 | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF WITNESSES | |
| | | | |
| DATE | | DATE | |
| NOV. 1967 | | NOV. 1967 | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | |
| | | | |
| DATE | | DATE | |
| NOV. 1967 | | NOV. 1967 | |

RECEIVED
JUL 23 1967
BUREAU V. S.

1 MD 03 1 VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07334

CERTIFICATE OF DEATH

07319
Reg. Dist. No. 74

| | | | | | | | |
|--|-------------------------------|---|---|---|-----------------|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | | | c. LENGTH OF STAY IN 1b 118 days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15X22 | | | | ✓ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | | | d. STREET ADDRESS Rt. 2, Box 95 Stewart Lane | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Frank | | First Frank | | Middle Jones Jr. | | Last Jones Jr. | |
| 4. DATE OF DEATH July 27 1957 | | Month July | | Day 27 | | Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH August 25, 1927 | 9. AGE (In years last birthday) 29 yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Frank Jones | | | | 14. MOTHER'S MAIDEN NAME Pearl ??? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 579-28-4779 | | 17. INFORMANT Frank Jones - Patient Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral pulmonary tuberculosis with cavitation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 29, 1957 , to July 26, 1957 , that I last saw the deceased alive on July 26, 1957 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 7-27-57 ACTUAL SIGNATURE E. M. Maculans M.D. Henryton, Maryland PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans Henryton State Hospital, Henryton, Md | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-1-57 | | 22c. NAME OF CEMETERY OR CREMATORY Int Calvary | | 22d. LOCATION (City, town, or county) (State) Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Geo M. Nelson ADDRESS 1348 N. Calhoun St | | | | 24a. REC'D BY REGISTRAR 7-27-57 | | 24b. REGISTRAR'S SIGNATURE Albert R. Swathman | |

CERTIFICATE OF DEATH

1891

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED JAMES J. JONES | | 2. SEX Male | | 3. AGE 35 years | | 4. DATE OF DEATH April 10, 1901 | |
| 5. PLACE OF DEATH Home | | 6. CITY Baltimore | | 7. COUNTY Baltimore | | 8. STATE Maryland | |
| 9. OCCUPATION Clerk | | 10. CAUSE OF DEATH Typhoid fever | | 11. DISEASE Typhoid fever | | 12. MEDICAL HISTORY None | |
| 13. NAME OF PHYSICIAN Dr. J. J. Jones | | 14. NAME OF FUNERAL HOME None | | 15. NAME OF BURIAL PLACE None | | 16. NAME OF CEMETERY None | |
| 17. NAME OF NEXT OF KIN None | | 18. NAME OF WITNESS None | | 19. NAME OF REGISTRAR None | | 20. NAME OF CLERK None | |
| 21. NAME OF DECEASED'S MOTHER None | | 22. NAME OF DECEASED'S FATHER None | | 23. NAME OF DECEASED'S BROTHER None | | 24. NAME OF DECEASED'S SISTER None | |
| 25. NAME OF DECEASED'S WIFE None | | 26. NAME OF DECEASED'S CHILDREN None | | 27. NAME OF DECEASED'S GRANDCHILDREN None | | 28. NAME OF DECEASED'S GREAT-GRANDCHILDREN None | |
| 29. NAME OF DECEASED'S GREAT-GRANDPARENTS None | | 30. NAME OF DECEASED'S GREAT-GRANDFATHER None | | 31. NAME OF DECEASED'S GREAT-GRANDMOTHER None | | 32. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 33. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 34. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 35. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 36. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 37. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 38. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 39. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 40. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 41. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 42. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 43. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 44. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 45. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 46. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 47. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 48. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 49. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 50. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 51. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 52. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 53. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 54. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 55. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 56. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 57. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 58. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 59. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 60. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 61. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 62. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 63. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 64. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 65. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 66. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 67. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 68. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 69. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 70. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 71. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 72. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 73. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 74. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 75. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 76. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 77. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 78. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 79. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 80. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 81. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 82. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 83. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 84. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 85. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 86. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 87. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 88. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 89. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 90. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 91. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 92. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 93. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 94. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 95. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 96. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |
| 97. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 98. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 99. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | | 100. NAME OF DECEASED'S GREAT-GRANDSIBLINGS None | |

BUREAU V. 1

APR 31 1901

RECEIVED

(7335)

CERTIFICATE OF DEATH

Reg. Dist. No.

74

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 1 mo. 10 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick 10352 | | | |
| 4. DATE OF DECEASED (Type or print) First Elma Middle Carnetta Last LaPOLE | | | | 4. DATE OF DEATH Month July Day 31 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 13, 1918 | |
| 9. AGE (In years last birthday) 39 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse's Aide | | | | 10b. KIND OF BUSINESS OR INDUSTRY 2 - | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Charles LaPole | | | | 14. MOTHER'S MAIDEN NAME Lula Taulton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No - | | | | 16. SOCIAL SECURITY NO. 214-20-7030 | | 17. INFORMANT Springfield Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrosis of brain, left hemisphere 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with unknown or unspecified cause, with psychotic reaction. 306X | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Unknown |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 21, 1957 , to July 31, 1957 , that I last saw the deceased alive on July 31, 1957 , and that death occurred at 9:00 AM , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) Walther H. Sonnenfeldt, M.D. Springfield State Hospital | | | | DATE SIGNED 7/31/57 | | | |
| ACTUAL SIGNATURE Walther H. Sonnenfeldt, M.D. | | | | PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 8-3-57 | | 22b. DATE THEREOF 8-3-57 | | 22c. NAME OF CEMETERY OR CREMATORY Reformed Mt. Zion | | 22d. LOCATION (City, town, or county) (State) Brunswick, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E.H. Feib | | | | 24a. REC'D BY REGISTRAR 7/31/57 | | | |
| 24b. REGISTRAR'S SIGNATURE C. Harry Heers | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A.

1957 2 500

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07336

CERTIFICATE OF DEATH

07321 74

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRINGFIELD STATE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 12 3401-4</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | d. STREET ADDRESS <u>6406 CLEARSPRING Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Walter Frederick LEWIN</u> | | | | 4. DATE OF DEATH Month <u>JULY</u> Day <u>13</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-7-92</u> | |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Warren Co. Va.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>William Lewin</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Earthman</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>1917-1919</u> | | | | 16. SOCIAL SECURITY NO. <u>218-148630</u> | | 17. INFORMANT <u>Thelma Lewin (wife) - CLEARSPRING</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CBS cerebral arteriosclerosis.</u> (c) <u>334X Fever of unknown etiology</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>334X</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>June 18, 1957</u> , to <u>July 13, 1957</u> , that I last saw the deceased alive on <u>July 13, 1957</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7-13-57</u> ACTUAL SIGNATURE <u>Walter H. Springfield</u> M.D. PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>July 16-1957</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn F. Seitz</u> ADDRESS <u>5209 York Rd</u> 24a. REC'D BY REGISTRAR DATE <u>7/15/57</u> 24b. REGISTRAR'S SIGNATURE <u>C. Harry Myers</u> | | | | | | | |

CERTIFICATE OF DEATH

1957

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. SEX a. MALE <input type="checkbox"/> b. FEMALE <input type="checkbox"/> | |
| 3. DATE OF DEATH a. MONTH <input type="text"/> b. DAY <input type="text"/> c. YEAR <input type="text"/> | | 4. TIME OF DEATH a. HOUR <input type="text"/> b. MINUTE <input type="text"/> | |
| 5. PLACE OF DEATH a. HOME <input type="checkbox"/> b. HOSPITAL <input type="checkbox"/> c. NURSING HOME <input type="checkbox"/> d. OTHER <input type="checkbox"/> | | 6. CAUSE OF DEATH a. DISEASE <input type="checkbox"/> b. INJURY <input type="checkbox"/> c. POISONING <input type="checkbox"/> d. OTHER <input type="checkbox"/> | |
| 7. NAME OF DECEASED a. FIRST <input type="text"/> b. MIDDLE <input type="text"/> c. LAST <input type="text"/> | | 8. AGE a. YEARS <input type="text"/> b. MONTHS <input type="text"/> c. DAYS <input type="text"/> | |
| 9. OCCUPATION a. <input type="text"/> | | 10. MARITAL STATUS a. SINGLE <input type="checkbox"/> b. MARRIED <input type="checkbox"/> c. DIVORCED <input type="checkbox"/> d. WIDOWED <input type="checkbox"/> | |
| 11. PLACE OF BIRTH a. STATE <input type="text"/> b. COUNTY <input type="text"/> | | 12. DATE OF BIRTH a. MONTH <input type="text"/> b. DAY <input type="text"/> c. YEAR <input type="text"/> | |
| 13. NAME OF PHYSICIAN a. <input type="text"/> | | 14. NAME OF HOSPITAL a. <input type="text"/> | |
| 15. NAME OF NURSING HOME a. <input type="text"/> | | 16. NAME OF OTHER PLACE a. <input type="text"/> | |
| 17. NAME OF DECEASED a. <input type="text"/> | | 18. NAME OF DECEASED a. <input type="text"/> | |
| 19. NAME OF DECEASED a. <input type="text"/> | | 20. NAME OF DECEASED a. <input type="text"/> | |
| 21. NAME OF DECEASED a. <input type="text"/> | | 22. NAME OF DECEASED a. <input type="text"/> | |
| 23. NAME OF DECEASED a. <input type="text"/> | | 24. NAME OF DECEASED a. <input type="text"/> | |
| 25. NAME OF DECEASED a. <input type="text"/> | | 26. NAME OF DECEASED a. <input type="text"/> | |
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| 29. NAME OF DECEASED a. <input type="text"/> | | 30. NAME OF DECEASED a. <input type="text"/> | |
| 31. NAME OF DECEASED a. <input type="text"/> | | 32. NAME OF DECEASED a. <input type="text"/> | |
| 33. NAME OF DECEASED a. <input type="text"/> | | 34. NAME OF DECEASED a. <input type="text"/> | |
| 35. NAME OF DECEASED a. <input type="text"/> | | 36. NAME OF DECEASED a. <input type="text"/> | |
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| 39. NAME OF DECEASED a. <input type="text"/> | | 40. NAME OF DECEASED a. <input type="text"/> | |
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| 49. NAME OF DECEASED a. <input type="text"/> | | 50. NAME OF DECEASED a. <input type="text"/> | |
| 51. NAME OF DECEASED a. <input type="text"/> | | 52. NAME OF DECEASED a. <input type="text"/> | |
| 53. NAME OF DECEASED a. <input type="text"/> | | 54. NAME OF DECEASED a. <input type="text"/> | |
| 55. NAME OF DECEASED a. <input type="text"/> | | 56. NAME OF DECEASED a. <input type="text"/> | |
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| 59. NAME OF DECEASED a. <input type="text"/> | | 60. NAME OF DECEASED a. <input type="text"/> | |
| 61. NAME OF DECEASED a. <input type="text"/> | | 62. NAME OF DECEASED a. <input type="text"/> | |
| 63. NAME OF DECEASED a. <input type="text"/> | | 64. NAME OF DECEASED a. <input type="text"/> | |
| 65. NAME OF DECEASED a. <input type="text"/> | | 66. NAME OF DECEASED a. <input type="text"/> | |
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| 71. NAME OF DECEASED a. <input type="text"/> | | 72. NAME OF DECEASED a. <input type="text"/> | |
| 73. NAME OF DECEASED a. <input type="text"/> | | 74. NAME OF DECEASED a. <input type="text"/> | |
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| 79. NAME OF DECEASED a. <input type="text"/> | | 80. NAME OF DECEASED a. <input type="text"/> | |
| 81. NAME OF DECEASED a. <input type="text"/> | | 82. NAME OF DECEASED a. <input type="text"/> | |
| 83. NAME OF DECEASED a. <input type="text"/> | | 84. NAME OF DECEASED a. <input type="text"/> | |
| 85. NAME OF DECEASED a. <input type="text"/> | | 86. NAME OF DECEASED a. <input type="text"/> | |
| 87. NAME OF DECEASED a. <input type="text"/> | | 88. NAME OF DECEASED a. <input type="text"/> | |
| 89. NAME OF DECEASED a. <input type="text"/> | | 90. NAME OF DECEASED a. <input type="text"/> | |
| 91. NAME OF DECEASED a. <input type="text"/> | | 92. NAME OF DECEASED a. <input type="text"/> | |
| 93. NAME OF DECEASED a. <input type="text"/> | | 94. NAME OF DECEASED a. <input type="text"/> | |
| 95. NAME OF DECEASED a. <input type="text"/> | | 96. NAME OF DECEASED a. <input type="text"/> | |
| 97. NAME OF DECEASED a. <input type="text"/> | | 98. NAME OF DECEASED a. <input type="text"/> | |
| 99. NAME OF DECEASED a. <input type="text"/> | | 100. NAME OF DECEASED a. <input type="text"/> | |

BUREAU V. H.

JUL 16 1957

RECEIVED

07337

CERTIFICATE OF DEATH

07322

Reg. Dist. No.

74

| | | | | | | | |
|--|----------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 2-10-1942 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS 2811 Winchester St | | | |
| 3. NAME OF DECEASED (Type or print) John First A. Middle Mudd Last | | | | 4. DATE OF DEATH July 28 1957 Month July Day 28 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan 24 1887 | 9. AGE (In years less birthday) yrs. 70 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. watchman | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) White Plains Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Bernard Mudd | | | | 14. MOTHER'S MAIDEN NAME Annie Franklin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Springfield State Hospital- Sykesville Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 minutes about 20 yrs | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 025x Psychosis with syphilitic meningo encephalitis | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 17 1955 19 57 , to & 7-28-57 , that I last saw the deceased alive on July 7, 1955 19 57 , and that death occurred at 9:00 a.m. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) EDMUND LUSTHAUS Sykesville Md | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/30/57 | | 22c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. J. Lohman & Son | | | | 24a. REC'D BY REGISTRAR DATE 7/29/57 | | 24b. REGISTRAR'S SIGNATURE C. Harry Myers | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | |
|------------------------|--|----------------------|--|
| PLACE OF DEATH | | CITY | |
| COUNTY | | STATE | |
| DATE OF DEATH | | TIME OF DEATH | |
| AGE | | SEX | |
| RACE | | RELIGION | |
| EDUCATION | | OCCUPATION | |
| MARRIAGE | | PREVIOUS ILLNESS | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | |
| SIGNATURE OF JUDGE | | SIGNATURE OF CLERK | |

BUREAU V. R.

JUL 30 1957

RECEIVED

(7338

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 2 yrs. 21 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. STREET ADDRESS 2126 St. Paul Street | | | |
| 3. NAME OF DECEASED (Type or print) First Anna Middle Christine Last OLSEN | | | | 4. DATE OF DEATH Month July Day 29 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 27, 1884 | |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Norway | |
| 13. FATHER'S NAME Even Olsen | | | | 14. MOTHER'S MAIDEN NAME Inger Olsen Hansen | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 306x (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with circulatory disturbance with cerebral arterio-sclerosis with psychotic reaction. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from July 8, 19 55 , to July 29, 19 57 , that I last saw the deceased alive on July 29, 19 57 , and that death occurred at 8:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D. Springfield State Hospital 7/30/57 PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/2/57 | | 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | | 22d. LOCATION (City, town, or county) _____ (State) _____ Woodlawn, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jim. J. Lickner & Sons, Balto. | | | | ADDRESS 17th St. | | 24a. REC'D BY REGISTRAR DATE 7/31/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE C. Harry Myers | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

(7339

CERTIFICATE OF DEATH

0732474

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 406 Camden Street | |
| 3. NAME OF DECEASED (Type or print) First Leonard Middle PEKTUS Last PEKTUS | | 4. DATE OF DEATH Month July Day 28 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1869 |
| 9. AGE (In years lost birthday) 88 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Lithuania | | 12. CITIZEN OF WHAT COUNTRY? Lithuania | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |

| | | |
|--|---|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 306X (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 10 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Psychosis with cerebral arteriosclerosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) _____ (County) _____ (State) _____ | | |
| 21. I certify that I attended the deceased from July 1 , 19 50 , to July 28 , 19 57 , that I last saw the deceased alive on July 28 , 19 57 , and that death occurred at 11:40 PM , from the causes and on the date stated above. | | |
| ADDRESS (Street, city or town, state) Walther H. Sonnenfeldt, M.D. Springfield State Hospital | | DATE SIGNED 7/29/57 |
| ACTUAL SIGNATURE Walther H. Sonnenfeldt, M.D. | | |
| PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY |
| 22d. LOCATION (City, town, or county) _____ (State) _____ | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Henschel, Baltimore, Md. | | 24a. REC'D BY REGISTRAR AUG 1 1957 |
| 24b. REGISTRAR'S SIGNATURE C. Harry Hays | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

C7340

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 3 mos. 3 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Charles Middle Wesley Last PRICE, Sr. | | | | 4. DATE OF DEATH Month July Day 22 Year 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 20, 1883 | 9. AGE (In years last birthday) 73 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Price | | | 14. MOTHER'S MAIDEN NAME Mannie Price | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Springfield State Hospital Records. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH Years Years Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334 C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from April 19, 1957 , to July 22, 1957 , that I last saw the deceased alive on July 22, 1957 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo | | | ADDRESS (Street, city or town, state) Springfield State Hospital | | DATE SIGNED 7/22/57 | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | | Sykesville, Maryland. | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) B | 22b. DATE THEREOF 7/24/57 | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park | | 22d. LOCATION (City, town, or county) (State) Baltimore | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Ave. | | | ADDRESS | | 24a. REC'D BY REGISTRAR JUL 24 1957 | 24b. REGISTRAR'S SIGNATURE C. Harry Heery | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

JUL 24 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07327

Reg. Dist. No. 81

07341

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> | | c. LENGTH OF STAY IN lb <u>2 YRS.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DEADWATER</u> | | d. STREET ADDRESS <u>30 W. BROADWAY</u> | |
| 3. NAME OF DECEASED (Type or print) <u>WILSON HANSBOROUGH QUESENBERRY</u> | | 4. DATE OF DEATH <u>JULY 8 1957</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC 31, 1880</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> Hours <u>10</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY FARMING</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | |
| 13. FATHER'S NAME <u>CROCKETT QUESENBERRY</u> | | 14. MOTHER'S MAIDEN NAME <u>NANCY DUNCAN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Russell V. Lushby</u> | | Address <u>Linwood, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Coronary Sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH <u>min.</u> <u>year.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>James J. Marsh</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>JULY 10, 1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEMETARY INC.</u> | | 22d. LOCATION (City, town, or county) (State) <u>CARROLL CO. MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler & Sons, Union Bridge Md</u> | | 24a. REC'D BY REGISTRAR <u>Leslie L. Rapp</u> | |
| 24b. REGISTRAR'S SIGNATURE | | DATE <u>7/9/57</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU VI

DEC 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(7342

CERTIFICATE OF DEATH

07328

Reg. Dist. No. 44

| | | | | | | | |
|--|----------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN lb 7 mos. 28 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Vo1-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS 5507 Craig Avenue | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Maud Middle Mary Last REES | | | | 4. DATE OF DEATH Month July Day 10 Year 19 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 2, 1875 | | 9. AGE (In years last birthday) yrs. 81 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician | | 10b. KIND OF BUSINESS OR INDUSTRY Medicine | | 11. BIRTHPLACE (State or foreign country) Rhode Island | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Rees | | | | 14. MOTHER'S MAIDEN NAME Elsa Holt | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. unk. | | 17. INFORMANT Address Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of aorta due to arteriosclerosis 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis, without qualifying phrase. 334X | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from November 11, 1956 , to July 10, 1957 , that I last saw the deceased alive on July 9, 1957 , and that death occurred at 3:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/10/57 ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Removal | | 7-13-57 | | Short Lincoln | | Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Luther H. Knight | | | | ADDRESS Sykesville, Md. | | 24a. REC'D BY REGISTRAR DATE 7-11-57 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE C. Harry Weaver | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07329

Reg. Dist. No. 26

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, R-3, Myers District | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Virginia Middle — Last Sell | | 4. DATE OF DEATH Month July Day 22 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 7, 1869 |
| 9. AGE (In years last birthday) 89 yrs. | | 10. IF UNDER 1 YEAR: Months — Days — Hours — Min. — | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework, Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home. | |
| 11. BIRTHPLACE (State or foreign country) Carroll Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Lippy | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Serenus Sell Address Serenus Sell, R. D. 3, Westminster, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 260x DUE TO Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0 INTERVAL BETWEEN ONSET AND DEATH 5 yrs 6 mon | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 18, 1957 , to July 22, 1957 , that I last saw the deceased alive on July 18, 1957 , and that death occurred at 2 M from the causes and on the date stated above. ADDRESS (Street, city or town, state) Manchester, Md DATE SIGNED 7/22/57 ACTUAL SIGNATURE W. H. Ford M.D. W. H. Ford. M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/25/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Bixlers U.B. Cemetery | | 22d. LOCATION (City, town, or county) (State) Nr. Westminster, Carroll Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little | | ADDRESS Littlestown, Pa. | |
| 24a. REC'D BY REGISTRAR 2-24-57 | | 24b. REGISTRAR'S SIGNATURE Harriet Muller | |

07308

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|--|---|-----------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> | | | | c. LENGTH OF STAY IN 1b <u>9 YRS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 JOHN ST.</u> | | | | d. STREET ADDRESS <u>11 JOHN ST</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>NELLIE CATHERINE SENTZ</u> | | | | 4. DATE OF DEATH <u>JULY 22 1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCTOBER 3-1905</u> | 9. AGE (In years last birthday) <u>57</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE + CLERK LUNCH ROOM MD</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>USA</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>CHARLES L. FOX</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ELVIA BINDIG</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>22-16-079</u> | | 17. INFORMANT <u>MRS GEO. HARRIS WESTMINSTER, MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>442X</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>15 yrs.</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>12/6</u> 19 <u>57</u> , to <u>7/22</u> 19 <u>57</u> , that I last saw the deceased alive on <u>7/22</u> 19 <u>57</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>G. Allen Moulton</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Westminster Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>G. ALLEN MOULTON, M.D.</u> | | | | DATE SIGNED <u>7/27/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>7-25-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER PEN.</u> | | 22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bamford Westminster Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 7-26-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WESTMINSTER

WILLIE C. THOMPSON

BUREAU V. 3

JUL 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(7344)

07331

Reg. Dist. No. 74

| | | | |
|--|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | c. LENGTH OF STAY IN lb <u>6 days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland, Md.</u> 11 X 22 | | d. STREET ADDRESS <u>Route 1, Oakland</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Charles Daniel Sr. Shaeffer</u> | | 4. DATE OF DEATH <u>7 19 19 57</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-24-81</u> |
| 9. AGE (In years last birthday) <u>75 yrs.</u> | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawmill operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Ynk</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Henry Shaeffer</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unkn</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Unkn</u> | |
| 17. INFORMANT <u>S.S. Hospital Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerotic heart disease</u> <u>Fractured 7,8,9 left ribs</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Chr. brain syndr. with cerebral arteriosclerosis with psychosis</u> <u>42218</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>unknown</u> | | 20b. HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>unknown; apparently prior to admission to this hospital</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>James T. Marsh</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>James T. Marsh</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED <u>7/20/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7-23-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Anora</u> | | 22d. LOCATION (City, town, or county) (State) <u>Anora, W. Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas Roy Golden - Oakland, Md.</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <u>7-20-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u> | |

RECEIVED

JUL 24 1957

BUREAU V. S.

07309

07332

CERTIFICATE OF DEATH

Reg. Dist. No.

76

| | | | | | | | |
|---|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster | | | | c. LENGTH OF STAY IN 1b 15 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 170 E. Green St. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First George Middle Morgan Last Simpson | | | | 4. DATE OF DEATH Month July Day 4 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 18, 1886 | 9. AGE (In years last birthday) 71 yrs. | IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. 71 | IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min. 71 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Paper Dist. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Francis Marion Simpson | | | | 14. MOTHER'S MAIDEN NAME Mary McTaggart | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknowns) no | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Address Mrs. Anna Boyd Simpson Westminster, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) 5 years | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 7/4 , 19 57 , to 7/4 , 19 57 , that I last saw the deceased alive on 7/4 , 19 57 , and that death occurred at 6:17 M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE S. Luther Bare M.D. | | | | ADDRESS (Street, city or town, state) Westminster, Maryland DATE SIGNED 7/5/57 | | | |
| PHYSICIAN'S NAME (Type) S. Luther Bare, M. D. | | | | 79 W. Main St. Westminster, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-7-57 | | 22c. NAME OF CEMETERY OR CREMATORY Krider's Cemetery | | 22d. LOCATION (City, town, or county) (State) nr Westminster, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Maryland | | | | 24a. REC'D BY REGISTRAR DATE 7-8-57 | | 24b. REGISTRAR'S SIGNATURE Harriet Miller | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JUL 10 1957

RECEIVED

C7345

CERTIFICATE OF DEATH

Reg. Dist. No. 74

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 32 yrs. 8 mos. 17 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS - | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Walter Middle Skrypek Last Skrypek | | | | 4. DATE OF DEATH Month July Day 9 Year 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 25, 1893 | | 9. AGE (In years last birthday) 63 yrs. | IF UNDER 1 YEAR Months 63 | IF UNDER 24 HRS. Days 63 Hours 63 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY - Unk. | | 11. BIRTHPLACE (State or foreign country) Austria | | 12. CITIZEN OF WHAT COUNTRY? Austria | |
| 13. FATHER'S NAME John Skrypek | | | | 14. MOTHER'S MAIDEN NAME Rosa Bubula | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unk. | | 17. INFORMANT Springfield Hospital records. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days Years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia reaction, paranoid type. | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 1, 19 50 , to July 9, 19 57 , that I last saw the deceased alive on July 9, 19 57 , and that death occurred at 11: A M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Walther H. Sonnenfeldt | | | | ADDRESS (Street, city or town, state) Springfield State Hospital | | | |
| PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. | | | | DATE SIGNED 7/9/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 7-11-57 | | Springfield | | Sykesville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight | | | | 24a. REC'D BY REGISTRAR DATE 7-10-57 | | 24b. REGISTRAR'S SIGNATURE R. Harry Ewer | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---------------------------|--|---------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. RACE | | 5. BIRTH DATE | | 6. BIRTH PLACE | |
| 7. MARRIAGE | | 8. OCCUPATION | | 9. CAUSE OF DEATH | |
| 10. PLACE OF DEATH | | 11. DATE OF DEATH | | 12. TIME OF DEATH | |
| 13. SIGNATURE OF DECEASED | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF PHYSICIAN | |
| 16. SIGNATURE OF CLERK | | 17. SIGNATURE OF JUDGE | | 18. SIGNATURE OF SHERIFF | |
| 19. SIGNATURE OF CORONER | | 20. SIGNATURE OF JURY | | 21. SIGNATURE OF JUDGE | |
| 22. SIGNATURE OF SHERIFF | | 23. SIGNATURE OF SHERIFF | | 24. SIGNATURE OF SHERIFF | |
| 25. SIGNATURE OF SHERIFF | | 26. SIGNATURE OF SHERIFF | | 27. SIGNATURE OF SHERIFF | |
| 28. SIGNATURE OF SHERIFF | | 29. SIGNATURE OF SHERIFF | | 30. SIGNATURE OF SHERIFF | |
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| 94. SIGNATURE OF SHERIFF | | 95. SIGNATURE OF SHERIFF | | 96. SIGNATURE OF SHERIFF | |
| 97. SIGNATURE OF SHERIFF | | 98. SIGNATURE OF SHERIFF | | 99. SIGNATURE OF SHERIFF | |
| 100. SIGNATURE OF SHERIFF | | 101. SIGNATURE OF SHERIFF | | 102. SIGNATURE OF SHERIFF | |

RECEIVED
JUL 12 1957
BUREAU V. M.

C7346

CERTIFICATE OF DEATH

Reg. Dist. No. 74

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 1 mo. 6 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Albert Middle Reid Last SMITH | | | | 4. DATE OF DEATH Month July Day 31 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 29, 1876 | |
| 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR Months 80 Days 0 Hours 0 Min. | | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Mose Smith | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) National Guard | | | | 16. SOCIAL SECURITY NO. 220-09-4887 | | 17. INFORMANT Springfield Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19 | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from June 25, 1957 , to July 31, 1957 , that I last saw the deceased alive on July 30, 1957 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/31/57 | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. Springfield State Hospital | | | | | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo Sykesville, Maryland. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | |
| 22b. DATE THEREOF 8-3-57 | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial | | | | | | | |
| 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Phenowette, Jr. ADDRESS 3615 Westgate Dr. Balt. | | | | | | | |
| 24a. REC'D BY REGISTRAR C. Harry | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE 7-31-57 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 18

| | | | |
|--|--|--|--|
| NAME OF DECEASED [Faint text, possibly "John Doe"] | | SEX [Faint text, possibly "Male"] | |
| AGE [Faint text, possibly "45 years"] | | DATE OF BIRTH [Faint text, possibly "Jan 15, 1880"] | |
| PLACE OF BIRTH [Faint text, possibly "Boston, Mass."] | | OCCUPATION [Faint text, possibly "Teacher"] | |
| CAUSE OF DEATH [Faint text, possibly "Heart Disease"] | | PLACE OF DEATH [Faint text, possibly "Home"] | |
| DATE OF DEATH [Faint text, possibly "June 10, 1925"] | | TIME OF DEATH [Faint text, possibly "10:30 AM"] | |
| SIGNATURE OF PHYSICIAN [Faint signature] | | SIGNATURE OF REGISTRAR [Faint signature] | |
| CITY [Faint text, possibly "Boston"] | | COUNTY [Faint text, possibly "Suffolk"] | |
| STATE [Faint text, possibly "Massachusetts"] | | YEAR [Faint text, possibly "1925"] | |

BUREAU V. S.

AUG 5 1927

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG218 7-30-57 et

07347

CERTIFICATE OF DEATH

07335

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 4 mos. 26 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS 4600 Valley View Ave. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First William Middle Boston Last SMITH | | | | 4. DATE OF DEATH Month July Day 24 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 20, 1883 | |
| 9. AGE (In years last birthday) 73 7/8 yrs. | | IF UNDER 1 YEAR Months 7 Days 4 Hours 14 Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die Maker | | | | 10b. KIND OF BUSINESS OR INDUSTRY Ymk | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William Boston Smith | | | | 14. MOTHER'S MAIDEN NAME Catherine Roben | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 216-05-1749A | | 17. INFORMANT Springfield Hospital Records. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis XXXXX Bronchopneumonia (c) Diabetes Mellitus | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with circ. dist. with cerebral arteriosclerosis with psychotic reaction. Cancer of the tongue. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 260X | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from February 28, 1957 , to July 24, 1957 , that I last saw the deceased alive on July 24, 1957 , and that death occurred at 7:35 P.M. from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) Springfield State Hospital | | | | DATE SIGNED 7/25/57 | | | |
| ACTUAL SIGNATURE Agustin del Campo | | | | M.D. Springfield State Hospital | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo | | | | Sykesville, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-24-57 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Yllrich | | | | ADDRESS 4210 Belair Rd. Balt. | | 24a. REC'D BY REGISTRAR DATE 7-25-57 | |
| 24b. REGISTRAR'S SIGNATURE C. Harry Zuer | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 26 1957

RECEIVED

7348

CERTIFICATE OF DEATH

Reg. Dist. No.

94

| | | | |
|--|---------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 3 mos. 6 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 3207 Independence St. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Annie Corrilla Hinton TAYLOR | | 4. DATE OF DEATH Month Day Year July 23, 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 5, 1870 |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Hinton | | 14. MOTHER'S MAIDEN NAME Margaret Maddon | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right lung 420.1 XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Old myocardial infarction of left ventricle wall Years (c) Coronary arteriosclerosis Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease, with psychotic reaction. 306 X | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 17, 1957 to 7-23- 19 57 , that I last saw the deceased alive on 7-23- 19 57 , and that death occurred at 6.40 p. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Walter H. Sonnenfeldt M.D. | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7-23-57 | |
| PHYSICIAN'S NAME (Type) Walter H. Sonnenfeldt, M.D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF July 27/1957 | 22c. NAME OF CEMETERY OR CREMATORY London Park | 22d. LOCATION (City, town, or county) (State) Baltimore Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Melville Jenkins ADDRESS 2713 Kirk Ave | | 24a. REC'D BY REGISTRAR 7/26/57 | 24b. REGISTRAR'S SIGNATURE C. Harry Sears |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1, 1957

| | | | | | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED [Illegible] | | 2. SEX [Illegible] | | 3. AGE [Illegible] | |
| 4. DATE OF DEATH [Illegible] | | 5. TIME OF DEATH [Illegible] | | 6. PLACE OF DEATH [Illegible] | |
| 7. CAUSE OF DEATH [Illegible] | | 8. MANNER OF DEATH [Illegible] | | 9. PLACE OF BIRTH [Illegible] | |
| 10. OCCUPATION [Illegible] | | 11. EDUCATION [Illegible] | | 12. MARITAL STATUS [Illegible] | |
| 13. PREVIOUS MARRIAGES [Illegible] | | 14. PREVIOUS DEATHS [Illegible] | | 15. PREVIOUS INMATE [Illegible] | |
| 16. PREVIOUS ARRESTS [Illegible] | | 17. PREVIOUS CONFINEMENT [Illegible] | | 18. PREVIOUS DEPORTATION [Illegible] | |
| 19. PREVIOUS SENTENCE [Illegible] | | 20. PREVIOUS PROBATION [Illegible] | | 21. PREVIOUS PAROLE [Illegible] | |
| 22. PREVIOUS PARDON [Illegible] | | 23. PREVIOUS COMMUTATION [Illegible] | | 24. PREVIOUS REMITTANCE [Illegible] | |
| 25. PREVIOUS WRIT OF HABEAS CORPUS [Illegible] | | 26. PREVIOUS WRIT OF HABEAS AD ADJUDICATION [Illegible] | | 27. PREVIOUS WRIT OF HABEAS AD RESTITUTION [Illegible] | |
| 28. PREVIOUS WRIT OF HABEAS AD REPARATION [Illegible] | | 29. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 30. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 31. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 32. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 33. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 34. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 35. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 36. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 37. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 38. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 39. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 40. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 41. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 42. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 43. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 44. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 45. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 46. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 47. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 48. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 49. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 50. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 51. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 52. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 53. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 54. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 55. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 56. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 57. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 58. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 59. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 60. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 61. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 62. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 63. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 64. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 65. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 66. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 67. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 68. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 69. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 70. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 71. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 72. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 73. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 74. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 75. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 76. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 77. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 78. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 79. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 80. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 81. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 82. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 83. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 84. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 85. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 86. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 87. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 88. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 89. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 90. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 91. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 92. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 93. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 94. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 95. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 96. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 97. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 98. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 99. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |
| 100. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 101. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | | 102. PREVIOUS WRIT OF HABEAS AD REFORMATION [Illegible] | |

BUREAU V. S.

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07337

07349

CERTIFICATE OF DEATH

Reg. Dist. No.

74

| | | | | | | | |
|--|--|----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll County, Maryland MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery County | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Sykesville, Maryland | | | | c. LENGTH OF STAY IN lb 10 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) James Benson Taylor | | | | 4. DATE OF DEATH 7 21 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-4-1870 | |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Alfred Taylor | | | | 14. MOTHER'S MAIDEN NAME Virginia Boggs | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Hospital records | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Minutes Years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome due to cerebral arteriosclerosis with psychosis 306x | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 7-11-1957 , 19 57 , to 7-21 , 19 57 , that I last saw the deceased alive on 7-21 , 19 57 , and that death occurred at 11:55 A. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Gertrude M. Gross, M.D. | | | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7-21-1957 | | | |
| PHYSICIAN'S NAME (Type) Gertrude M. Gross, M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-23-57 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Smithland, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL HOME | | | | ADDRESS 4812-G-A, AVE Wash. DC | | 24a. REC'D BY REGISTRAR 28 19 57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Cherry Hays | | | |

Item 3: G218 7-24-57 L

CERTIFICATE OF DEATH

Reg. Dist. No.

74

| | | | | | | | |
|---|------------------------------|--|---------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 32 y1 m 28 d | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS 309 S. Eden Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Dominic Middle DELLA Last VIOLA Viola | | | | 4. DATE OF DEATH Month 7 Day 28 Year 1957 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1879 | | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? unknown | |
| 13. FATHER'S NAME unknown | | | | 14. MOTHER'S MAIDEN NAME Grace Divilmo | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn | | 16. SOCIAL SECURITY NO. unkn | | 17. INFORMANT S.S.Hospital Records Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia due to undetermined cause DUE TO 491 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epileptic psychosis 308.1 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10-20 , 19 54 , to 7-19-57 , 19 57 , that I last saw the deceased alive on 7-19- , 19 57 , and that death occurred at 4:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Edmund Luthaus | | | | M.D. Springfield State Hospital 7-20-57 | | | |
| PHYSICIAN'S NAME (Type) Edmund Luthaus | | | | Sykesville, Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF July 24, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Hope | | 22d. LOCATION (City, town, or county) (State) Baltimore Road Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Kippel | | | | 24a. REC'D BY REGISTRAR July 20, 1957 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE C. Harry Hess | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. 3

JUL 24 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

76

07310

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> | | | | c. LENGTH OF STAY IN 1b <u>YEARS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>COUNTY HOME</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>JACOB</u> First <u>RINEHART</u> Middle <u>ZILE</u> Last | | | | 4. DATE OF DEATH Month <u>JULY</u> Day <u>9</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>NOV 21-1874</u> | |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FATHERS FARM</u> | | 11. BIRTHPLACE (State of foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>LEONARD ZILE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARGARET STEVENSON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>GERTRUDE LAMBERT</u> Address <u>NEW WINDSOR MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio vas. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>no cause</u> DUE TO (c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>no</u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>no</u> | |
| 20f. (City or town) <u>no</u> | | | | 20g. (County) <u>no</u> | | 20h. (State) <u>no</u> | |
| 21. I certify that I attended the deceased from <u>June</u> 19 <u>48</u> to <u>7-9</u> 19 <u>57</u> , that I last saw the deceased alive on <u>July 8</u> 19 <u>57</u> , and that death occurred at <u>5:00 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>WESTMINSTER MD</u> DATE SIGNED <u> </u> | | | | | | | |
| ACTUAL SIGNATURE <u>W. C. Stone</u> | | | | M.D. <u>Westminster</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W. C. Stone</u> | | | | <u>WESTMINSTER MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>7/11/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u> | | 22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>D. Hartzler & Sons, New Windsor Md</u> | | | | ADDRESS <u> </u> | | 24a. REC'D BY REGISTRAR DATE <u>7/12/57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Harriet Mullis</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS

1957

BUREAU V. 3

JUL 12 1957

RECEIVED